

**Dr. Janice Avalone, Psy.D., LMFT**

Licensed Marriage & Family Therapist

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## **CONSENT TO TREAT A MINOR**

I/WE \_\_\_\_\_, parent (s) or legal guardian(s)  
parent(s)/guardian(s)

of \_\_\_\_\_, a minor, hereby consent to  
(minor)

counseling services of said minor by Dr. Janice Avalone, LMFT. I understand that children are entitled to a confidential relationship with their therapist, and I will respect that confidentiality.

SIGNED: \_\_\_\_\_

PRINT NAME: \_\_\_\_\_

Relationship to minor: \_\_\_\_\_ (mother, father, legal guardian)

SIGNED: \_\_\_\_\_

PRINT NAME: \_\_\_\_\_

Relationship to minor: \_\_\_\_\_ (mother, father, legal guardian)